the methodology for determining additional payments for outlier cases. Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system for inpatient operating costs. Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system for inpatient operating costs. Subpart K describes how the prospective payment system for inpatient operating costs is implemented for hospitals located in Puerto Rico. Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation. Subpart M describes how the prospective payment system for inpatient capital-related costs is implemented effective with cost reporting periods beginning on or after October 1, 1991.

[57 FR 39818, Sept. 1, 1992, as amended at 58 FR 46337, Sept. 1, 1993]

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in §412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that have an atypically long length of stay or are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph include the following:

(i) Limitation of liability days payable under the payment procedures for custodial care and services that are not reasonable and necessary as specified in §411.400 of this chapter.

(ii) Guarantee of payment days, as authorized under §409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(1) Operating costs for routine services (as described in §413.53(b) of this chapter), such as the costs of room, board, and routine nursing services;

(2) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(3) Special care unit operating costs (intensive care type unit services, as described in §413.53(b) of this chapter);

(4) Malpractice insurance costs related to services furnished to inpatients; and

(5) Certain preadmission services furnished by the hospital or by an entity wholly owned or operated by the hospital (that is, any entity for which the hospital itself is the sole owner or operator) to the patient during the 3 days immediately preceding the date of the patient's admission to the hospital. A hospital is considered the sole operator of an entity if the hospital has exclusive responsibility for conducting or overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. The specific preadmission services (other than ambulance services) included in the inpatient hospital operating costs are the following:

(i) Diagnostic services (including clinical diagnostic laboratory tests) furnished on or after January 1, 1991.

(ii) Other services related to the admission furnished on or after October 1, 1991. Other services related to the admission means services (other than diagnostic services) that are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient.

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§ 413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in § 413.85 of this chapter.

(3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in § 405.521 of this chapter.

(4) Heart, kidney, liver, and lung acquisition costs incurred by approved transplantation centers.

(5) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates for inpatient operating costs and inpatient capital-

related costs, hospitals receive payments for the following:

(1) Outlier cases, as described in subpart F of this part.

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in § 412.105 for inpatient operating costs and in § 412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in § 412.115.

(4) Bad debts of Medicare beneficiaries, as provided in § 412.115(a).

(5) ESRD beneficiary discharges if such discharges are ten percent or more of the hospital's total Medicare discharges, as provided in § 412.104.

(6) Serving a disproportionate share of low-income patients, as provided in § 412.106 for inpatient operating costs and § 412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in § 413.86 of this chapter.

(8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987; 53 FR 38526, Sept. 30, 1988; 55 FR 15173, Apr. 20, 1990; 55 FR 36068, Sept. 4, 1990; 57 FR 33897, July 31, 1992; 57 FR 39819, Sept. 1, 1992; 57 FR 46510, Oct. 9, 1992; 58 FR 46337, Sept. 1, 1993; 59 FR 1658, Jan. 12, 1994; 59 FR 45396, Sept. 1, 1994; 62 FR 46025, Aug. 29, 1997]

§ 412.4 Discharges and transfers.

(a) *Discharges.* A hospital inpatient is considered discharged when any of the following occurs:

(1) The patient is formally released from the hospital. (Release of the patient to another hospital as described in paragraph (b) of this section, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the prospective payment systems.)

(2) The patient dies in the hospital.

(3) The patient is transferred to a hospital or unit that is excluded from the prospective payment systems under subpart B of this part.

(b) *Transfers.* Except as provided under paragraph (a)(3) of this section, a discharge of a hospital inpatient is not counted for purposes of the prospective payment systems when the patient is transferred—

(1) From one inpatient area or unit of the hospital to another area or unit of the hospital;

(2) From the care of a hospital paid under this section to the care of another such hospital; or

(3) From the care of a hospital paid under this section to the care of another hospital—

(i) That is excluded from the prospective payment systems because of participation in an approved statewide cost control program or demonstration; or

(ii) Whose first cost reporting period under the prospective payment systems has not yet begun.

(c) *Payment in full to the discharging hospital.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with § 412.2(b).

(d) *Payment to a hospital transferring an inpatient to another hospital.* (1) A hospital that transfers an inpatient under the circumstances described in paragraph (b)(2) or (b)(3) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D, E, and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rates (as determined under subparts D, E, and M of this part) by the average length of stay for the specific Diagnosis-Related Group (DRG) into which the case falls. Payment is graduated by paying twice the per diem amount for the first day of the saty, and the per diem amount for each subsequent day, up to the limit described in paragraph (d)(1) of this section.

(2) However, if a discharge is classified into DRG No. 385 (Neonates, died or transferred) or DRG No. 456 (Burns,